FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018317

Facility Name: Scalabrini Life Center

Address: 10500 West Grand Avenue (Number) Franklin Park (City) 60131 (Zip Code)

County: Cook

Telephone Number: (847) 451-1520 **Fax #** (847) 451-1503

IDPA ID Number: 237061646001

Date of Initial License for Current Owners: 01/01/76

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,785	9,625	3,310	35,720	8
9	SNF/PED					9
10	ICF	7,437	3,884		11,321	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,222	13,509	3,310	47,041	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.27%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 12 and days of care provided 3,310

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	271,624	12,940	45,227	329,791		329,791		329,791			1
2	Food Purchase		214,857		214,857		214,857	(5,480)	209,377			2
3	Housekeeping	34,740	509	153,628	188,877		188,877		188,877			3
4	Laundry	38,625	1,807		40,432		40,432	25,509	65,941			4
5	Heat and Other Utilities			146,085	146,085		146,085		146,085			5
6	Maintenance	303,018	48,882	77,739	429,639		429,639	7,811	437,450			6
7	Other (specify):*											7
8	**TOTAL General Services**	648,007	278,995	422,679	1,349,681		1,349,681	27,840	1,377,521			8
	B. Health Care and Programs											
9	Medical Director			15,500	15,500		15,500		15,500			9
10	Nursing and Medical Records	1,525,662	181,032	849,003	2,555,697		2,555,697		2,555,697			10
10a	Therapy	44,369	325	24,442	69,136		69,136		69,136			10a
11	Activities	78,231	576		78,807		78,807		78,807			11
12	Social Services	154,701	2,016	2,524	159,241		159,241		159,241			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,802,963	183,949	891,469	2,878,381		2,878,381		2,878,381			16
	C. General Administration											
17	Administrative	63,269		428,048	491,317		491,317	(428,048)	63,269			17
18	Directors Fees											18
19	Professional Services			8,601	8,601		8,601	(8,601)				19
20	Dues, Fees, Subscriptions & Promotions			2,944	2,944		2,944	(300)	2,644			20
21	Clerical & General Office Expenses	146,148	25,118	37,478	208,744		208,744	481,691	690,435			21
22	Employee Benefits & Payroll Taxes			607,651	607,651		607,651		607,651			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,929	2,929		2,929		2,929			25
26	Insurance-Prop.Liab.Malpractice			11,532	11,532		11,532		11,532			26
27	Other (specify):*											27
28	**TOTAL General Administration**	209,417	25,118	1,099,183	1,333,718		1,333,718	44,742	1,378,460			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,660,387	488,062	2,413,331	5,561,780		5,561,780	72,582	5,634,362			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Scalabrini Life Center #0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			138,017	138,017		138,017	3,006	141,023			30
31	Amortization of Pre-Op. & Org.			89,316	89,316		89,316	(89,316)				31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,901	8,901		8,901		8,901			35
36	Other (specify):*											36
37	**TOTAL Ownership**			236,234	236,234		236,234	(86,310)	149,924			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,765	442,259		445,024		445,024		445,024			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):* Nonallowable costs			425	425		425	(425)				43
44	**TOTAL Special Cost Centers**	2,765	442,259	80,360	525,384		525,384	(425)	524,959			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,663,152	930,321	2,729,925	6,323,398		6,323,398	(14,153)	6,309,245			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,008)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,006	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(100)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(325)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(94,878)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,305)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,152		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,152		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (14,153)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Scalabrini Life Center
0018317
6/30/2001

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Deferred Maintenance	7,811	6
To offset Vending Income	(4,472)	2
Disallow Amortization of Goodwill	(89,316)	31
Disallow Chamber of Commerce Dues	(300)	20
Disallow Collection Expenses	(5,511)	19
Disallow Legal No Invoice	(3,090)	19
Total	**(94,878)**	

See Accountants' Compilation Report

Scalabrini Life Center

ID# 0018317

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Scalabrini Life Center # 0018317 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,008)	0	0	0	0	0	0	0	0	0	0	(1,008)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	25,509	0	0	0	0	0	0	0	0	0	25,509	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,008)	25,509	0	0	0	0	0	0	0	0	0	24,501	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(428,048)	0	0	0	0	0	0	0	0	0	(428,048)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	481,691	0	0	0	0	0	0	0	0	0	481,691	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	53,643	0	0	0	0	0	0	0	0	0	53,643	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,008)	79,152	0	0	0	0	0	0	0	0	0	78,144	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Scalabrini Life Center # 0018317 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,006	0	0	0	0	0	0	0	0	0	0	3,006	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,006	0	0	0	0	0	0	0	0	0	0	3,006	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(425)	0	0	0	0	0	0	0	0	0	0	(425)	43
44	**TOTAL Special Cost Centers**	(425)	0	0	0	0	0	0	0	0	0	0	(425)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,573	79,152	0	0	0	0	0	0	0	0	0	80,725	45

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached Schedule 6B				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Laundry Expenses	$	Resurrection Health Care	100.00%	$ 25,509	$ 25,509	1
2	V	17	Management Fee	428,048	Resurrection Health Care	100.00%		(428,048)	2
3	V	17	Administrator Wages	60,500	Resurrection Health Care	100.00%	60,500		3
4	V	21	Administrative Expenses		Resurrection Health Care	100.00%	481,691	481,691	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 488,548			$ 567,700	$ * 79,152	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Scalabrini Life Center
0018317
6/30/2001

Schedule 6A **Schedule of Board of Directors**

This is to affirm that the following board members of Scalabrini Life Center do not have any interest to provide Scalabrini Life Center with services or supplies.

Mr. Joseph F. Toomey	President
Sister Donna Marie Wolowicki	
Mr. Arthur B. Koenigsberger	Secretary
Mr. Robert Barrigar	
Michael Rosenberg	
Mr. Thomas Capobianco	Treasurer
Mrs. Florita De Jesus-Ortiz	Assistant Secretary

See Accountants' Compilation Report

Scalabrini Life Center
0018317
6/30/2001

Schedule 6B **Other Related Business Entities**

Name	City	Type of Business
Westlake Community Hospital	Melrose Park, IL	Hospital
Resurrection Life Center	Chicago, IL	Nursing Facility
Resurrection Medical Center	Chicago, IL	Hospital
Resurrection Retirement Community	Chicago, IL	Retirement Com.
Resurrection Nursing & Rehab Center	Park Ridge, IL	Nursing Facility
St Francis Nursing Facility	Evanston, IL	Nursing Facility
St Francis Nursing & Rehab Center	Evanston, IL	Nursing Facility
Westlake Hospital Skilled Nursing Unit	Melrose Park, IL	Nursing Facility
Maryhaven Nursing & Rehab Center	Glenview, IL	Nursing Facility
St. Benedict Nursing & Rehab Center	Niles, IL	Nursing Facility
Bethlehem Woods Retirement Community	LaGrange Park, IL	Retirement Com.
St Andrew Nursing & Rehab Center	Niles, IL	Nursing Facility
Villa Scalabrini Nursing & Rehab Center	Northlake, IL	Nursing Facility
Casa San Carlo Retirement Community	Northlake, IL	Retirement Com.
Holy Family Nursing & Rehab Center	Des Plaines, IL	Nursing Facility

See Accountants' Compilation Report

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Health Care
Street Address: 7435 West Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 792-9903
Fax Number: (773) 594-8567

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Laundry Expenses	Direct Cost	1	1	$ 25,509	$ none	1	$ 25,509	1
2	17	Administrator Wages	Direct Cost	1	1	60,500	60,500	1	60,500	2
3	21	Administrative Expenses	Direct Cost	1	1	481,691	none	1	481,691	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 567,700	$ 60,500		$ 567,700	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2					N/A							2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Scalabrini Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018317

CONTACT PERSON REGARDING THIS REPORT Rose Vitacco

TELEPHONE (773) 792-9903 FAX #: (773) 594-8567

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,250 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Four

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	148,750	1974	$ 221,420	1
2					2
3	TOTALS	148,750		$ 221,420	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1976	1976	$ 2,338,089	$ 67,302	Various	$ 67,302	$	$ 3,031,034	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various Improvements			1976	126,333		Various				9
10	Various Improvements			1983	116,680		Various				10
11	Various Improvements			1984	44,238		Various				11
12	Various Improvements			1985	66,220		Various				12
13	Various Improvements			1986	100,387		Various				13
14	Various Improvements			1987	69,243		Various				14
15	Various Improvements			1988	41,177		Various				15
16	Various Improvements			1989	35,358		Various				16
17	Various Improvements			1990	14,953		Various				17
18	Various Improvements			1991	32,337		Various				18
19	Various Improvements			1993	96,635		Various				19
20	Various Improvements			1994	136,996		Various				20
21	Various Improvements			1995	99,164		Various				21
22	Gazebo Improvements			1996	11,221		10				22
23	Landscaping			1996	3,162		10-12				23
24	Carpeting			1996	41,754		5				24
25	Remodeling			1996	42,239		10-15				25
26	Nurses' station, office improvements			1996	7,329		10-15				26
27	Landscaping			1996	9,620		10	962	962	4,809	27
28	Parking Lot Sewer Work			1997	2,500	250	10	250		1,000	28
29	Door Latch Hardware			1997	1,574	157	10	157		1,263	29
30	Lights			1997	3,201	320	10	320		1,280	30
31	Pharmacy Alarm Remodeling			1997	2,540	254	10	254		1,016	31
32	Roof			1998	84,833	8,483	10	8,483		29,691	32
33	Air conditioner overhaul			1998	20,444		10	2,044	2,044	6,132	33
34	Air conditioner coils			1999	14,550	1,455	10	1,455		3,274	34
35	Parking Lot Sewer			1999	1,500	150	10	150		338	35
36	Air Conditioning			1999	117,135	11,714	10	11,714		26,357	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscape Improvement	2000	$ 8,877	$ 444	10	$ 444	$	$ 444	37
38	Building Improvement - Furnish & Installing Flooring	2000	43,466	2,173	10	2,173		2,173	38
39	Building Improvement - Employee Entrance, Door&Cameras	2000	6,320	316	10	316		316	39
40	Building Improvements - Dining, Therapy & Shower Rooms	2000	24,855	1,243	10	1,243		1,243	40
41	Building Improvement - IDPH Plan Review Fee	2000	2,486	124	10	124		124	41
42	Fixed Equipment Improvement	2000	7,770	389	10	389		389	42
43	Fixed Equipment Improvement	2000	1,860	93	10	93		93	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,777,046	$ 94,867		$ 97,873	$ 3,006	$ 3,110,976	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,304,136	$ 40,644	$ 40,644	$	Various	$ 1,152,708	71
72	Current Year Purchases	50,111	2,506	2,506		10 yrs.	2,506	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,354,247	$ 43,150	$ 43,150	$		$ 1,155,214	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77		N/A								77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,352,713	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 138,017	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,023	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,006	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,266,190	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 8,901 Description: Copy Machine $7,909, Postage Meter $ 968, Maintenance Tools $24
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a C 3		hrs	$		$ 16,283	$		$ 16,283	1
2	Licensed Speech and Language Development Therapist	L 10a C 1,2&3	171	hrs	3,729		146	92	171	3,967	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L 10a C 1,2&3	1962	hrs	40,640		8,013	233	1,962	48,886	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L 39 C 1 & 2	82	# of prescrpts	2,765			417,753	82	420,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Special Mattresses	L 39 C 2						24,506		24,506	13
14	TOTAL				$ 47,134		$ 24,442	$ 442,584	2,215	$ 514,160	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 981,968	$ 981,968	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 632,811)	1,666,609	1,666,609	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,550	5,550	6
7	Other Prepaid Expenses	3,486	3,486	7
8	Accounts Receivable (owners or related parties)	60,006	60,006	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,717,619	$ 2,717,619	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	221,420	221,420	13
14	Buildings, at Historical Cost	3,783,800	3,777,046	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,317,429	1,354,247	16
17	Accumulated Depreciation (book methods)	(4,255,249)	(4,266,190)	17
18	Deferred Charges		2,785	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	1,518,346		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,585,746	$ 1,089,308	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,303,365	$ 3,806,927	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 39,515	$ 39,515	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	39,549	39,549	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,067	195,067	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,479	11,479	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17C	32,196	32,196	36
37	Due to Affiliates	2,840,499	2,840,499	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,158,305	$ 3,158,305	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,158,305	$ 3,158,305	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,145,060	$ 648,622	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,303,365	$ 3,806,927	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Scalabrini Life Center
0018317
6/30/2001

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Accrued Workers Compensation	27,000	27,000
Accrued Expenses	6,160	6,160
Accrued Payroll Liabilities	(964)	(964)
Total Line 36 - Other Current Liabilities(specify):	**32,196**	**32,196**

See Accountants' Compilation Report

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,178,422	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,178,422	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(33,362)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (33,362)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,145,060	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,438,287	1
2	Discounts and Allowances for all Levels	(2,701,099)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,737,188	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	417,390	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 417,390	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,008	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	490,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	551,179	21
22	Laundry	51,764	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,094,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,793	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,793	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	4,472	28
28a	Other Operating Inc.	20,300	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,772	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,290,036	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,349,681	31
32	Health Care	2,878,381	32
33	General Administration	1,333,718	33
	B. Capital Expense		
34	Ownership	236,234	34
	C. Ancillary Expense		
35	Special Cost Centers	445,449	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,323,398	40
41	**Income before Income Taxes (line 30 minus line 40)****	(33,362)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (33,362)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,002	2,130	$ 64,903	$ 30.47	1
2	Assistant Director of Nursing	1,911	2,015	52,409	26.01	2
3	Registered Nurses	21,816	23,511	542,307	23.07	3
4	Licensed Practical Nurses	11,733	12,780	228,404	17.87	4
5	Nurse Aides & Orderlies	48,529	52,870	538,853	10.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,920	2,133	44,369	20.80	7
8	Rehab/Therapy Aides	600	640	6,817	10.65	8
9	Activity Director	1,801	2,129	31,613	14.85	9
10	Activity Assistants	4,448	5,001	46,618	9.32	10
11	Social Service Workers	4,046	4,630	79,885	17.25	11
12	Dietician	1,220	1,256	18,865	15.02	12
13	Food Service Supervisor	928	960	20,005	20.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,403	24,448	232,754	9.52	15
16	Dishwashers					16
17	Maintenance Workers	24,342	27,247	303,018	11.12	17
18	Housekeepers	2,221	2,599	34,740	13.37	18
19	Laundry	4,373	4,852	38,625	7.96	19
20	Administrator	1,469	1,549	63,269	40.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,650	9,400	146,148	15.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	707	819	11,410	13.93	31
32	Other Health C: See Sch. 20A	8,277	8,905	155,375	17.45	32
33	Other(specify) See Sch. 20A	42	82	2,765	33.72	33
34	TOTAL (lines 1 - 33)	173,438	189,956	$ 2,663,152 *	$ 14.02	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 6,475	L. 1 C. 3	35
36	Medical Director	Monthly	15,500	L. 9 C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	16	800	L. 12 C. 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	$ 22,775		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,902	$ 148,207	L. 10 C.3	50
51	Licensed Practical Nurses	7,345	264,681	L. 10 C.3	51
52	Nurse Aides	20,768	436,115	L. 10 C.3	52
53	TOTAL (lines 50 - 52)	31,015	$ 849,003		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Scalabrini Life Center
0018317
6/30/2001

Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Plan Coordinator	1,645	1,885	42,782	22.70
Unit Receptionist	3,130	3,310	37,777	11.41
Chaplain	3,502	3,710	74,816	20.17
Total Line 32 - Other	**8,277**	**8,905**	**$ 155,375**	**$ 17.45**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Pharmacist	42	82	2,765	33.72
Total Line 33 - Other	**42**	**82**	**$ 2,765**	**$ 33.72**

See Accountants' Compilation Report

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelin Taylor	Administrator	0%	$ 5,653
Norma Wilson	Administrator	0%	57,616
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,269

B. Administrative - Other

Description	Amount
Resurrection Health Care - Management Fees	$ 428,048
(Management Fees adjusted out in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 428,048

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Mangum Smietanka & Johnson	Legal	$ 5,511
Seyfarth Shaw Fairwealth	Legal	3,090
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 8,601

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,937
Unemployment Compensation Insurance	5,011
FICA Taxes	185,554
Employee Health Insurance	350,938
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plans	19,505
Employee Tuition Reimbursement	3,313
Employee Physical	3,040
Other Employee Benefits	2,353
TOTAL (agree to Schedule V, line 22, col.8)	$ 607,651

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Life Services Network	1,333
Various Dues	627
Various Subscriptions	406
Various Licenses	278
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
N/A	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Scalabrini Life Center
Provider Number 0018317
July 1, 2000 - June 30, 2001

Schedule V, Line 25, Other Administration Staff Transportation:

VENDOR	DESCRIPTION	AMOUNT
Employee Reimb. Nursing Department	Mileage	100.00
Employee Reimb. Activity Department	Mileage	1,078.00
Employee Reimb. Physical Therapy Department	Mileage	427.00
Employee Reimb. Administration Department	Mileage	582.00
Employee Reimb. Social Service Department	Mileage	26.00
Employee Reimb. Housekeeping Department	Mileage	289.00
Employee Reimb. Facility Department	Mileage	157.00
Employee Reimb. Spiritual Department	Mileage	209.00
Employee Reimb. Dietary Department	Mileage	61.00
TOTAL		2,929.00

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	6/1998	$ 14,592	3	$ 2,432	$ 2,432	$ 4,864	$ 4,864	$	$	$	$	$
2	Air Conditioner Repairs	6/1998	2,910	3	485	970	970	485					
3	Painting & Decorating	6/1999	3,633	3		303	1,211	1,211	908				
4	Painting & Decorating	6/2000	3,754	3			626	1,251	1,251	626			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 24,889		$ 2,917	$ 3,705	$ 7,671	$ 7,811	$ 2,159	$ 626	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Scalabrini Life Center # 0018317 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $ 1,333**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **75,499** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,008**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will mail when completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	271,624	12,940	45,227	329,791	0	329,791	0	329,791
2. Food Purchase	0	214,857	0	214,857	0	214,857	-5,480	209,377
3. Housekeeping	34,740	509	153,628	188,877	0	188,877	0	188,877
4. Laundry	38,625	1,807	0	40,432	0	40,432	25,509	65,941
5. Heat and Other Utilities	0	0	146,085	146,085	0	146,085	0	146,085
6. Maintenance	303,018	48,882	77,739	429,639	0	429,639	7,811	437,450
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	648,007	278,995	422,679	1,349,681	0	1,349,681	27,840	1,377,521
9. Medical Director	0	0	15,500	15,500	0	15,500	0	15,500
10. Nursing & Medical Records	1,525,662	181,032	849,003	2,555,697	0	2,555,697	0	2,555,697
10a. Therapy	44,369	325	24,442	69,136	0	69,136	0	69,136
11. Activities	78,231	576	0	78,807	0	78,807	0	78,807
12. Social Services	154,701	2,016	2,524	159,241	0	159,241	0	159,241
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,802,963	183,949	891,469	2,878,381	0	2,878,381	0	2,878,381
17. Administrative	63,269	0	428,048	491,317	0	491,317	-428,048	63,269
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,601	8,601	0	8,601	-8,601	0
20. Fees, Subscriptions & Promotion	0	0	2,944	2,944	0	2,944	-300	2,644
21. Clerical & General Office	146,148	25,118	37,478	208,744	0	208,744	481,691	690,435
22. Employee Benefits & Payroll	0	0	607,651	607,651	0	607,651	0	607,651
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	2,929	2,929	0	2,929	0	2,929
26. Insurance-Prop.Liab.Malpractice	0	0	11,532	11,532	0	11,532	0	11,532
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	209,417	25,118	1,099,183	1,333,718	0	1,333,718	44,742	1,378,460
29. Total General Administrative	2,660,387	488,062	2,413,331	5,561,780	0	5,561,780	72,582	5,634,362
30. Depreciation	0	0	138,017	138,017	0	138,017	3,006	141,023
31. Amortization of Pre-Op. & Org.	0	0	89,316	89,316	0	89,316	-89,316	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	8,901	8,901	0	8,901	0	8,901
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	236,234	236,234	0	236,234	-86,310	149,924
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	2,765	442,259	0	445,024	0	445,024	0	445,024
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	79,935	79,935	0	79,935	0	79,935
43. Other (specify):*	0	0	425	425	0	425	-425	0
44. Total Special Cost Ce	2,765	442,259	80,360	525,384	0	525,384	-425	524,959
45. Grand Total	2,663,152	930,321	2,729,925	6,323,398	0	6,323,398	-14,153	6,309,245

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	981,968	981,968
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,666,609	1,666,609
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	5,550	5,550
7. Other Prepaid Expenses	3,486	3,486
8. Accounts Receivable-Owner/Related Party	60,006	60,006
9. Other (specify):	0	0
10. Total current assets	2,717,619	2,717,619
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	221,420	221,420
14. Buildings, at Historical Cost	3,783,800	3,777,046
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,317,429	1,354,247
17. Accumulated Depreciation (book methods)	-4,255,249	-4,266,190
18. Deferred Charges	0	2,785
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	1,518,346	0
24. Total Long-Term Assets	2,585,746	1,089,308
25. Total Assets	5,303,365	3,806,927
CURRENT LIABILITIES		
26. Accounts Payable	39,515	39,515
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	39,549	39,549
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	195,067	195,067
31. Accrued Taxes Payable	11,479	11,479
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	32,196	32,196
37. Other Current Liabilities (specify):	2,840,499	2,840,499
38. Total Current Liabilities	3,158,305	3,158,305
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	3,158,305	3,158,305
47.Total Equity	2,145,060	648,622
48.Total Liabilities and Equity	5,303,365	3,806,927

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,438,287
2. Discounts and Allowances for all Levels	-2,701,099
Subtotal - Inpatient Care	4,737,188
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	417,390
7. Oxygen	0
Subtotal - Anciliary Revenue	417,390
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,008
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	490,942
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	551,179
22. Laundry	51,764
Subtotal - Other Operating Revenue	1,094,893
24. Contributions	0
25. Interest and Other Investments Income	15,793
Subtotal - Non-Operating Revenue	15,793
27. Other Revenue (specify):	4,472
28. Other Revenue (specify):	20,300
Subtotal - Other Revenue	24,772
30. Total Revenue	6,290,036
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	3,540,420
42. Income Taxes	0
43. Net Income or Loss for the Year	3,540,420

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Scalabrini Life Center** **04:05 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-14,153	equal to	-14,153	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	141,023	equal to	141,023	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,901	equal to	8,901	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	47,134	equal to	47,134	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	69,136	equal to	69,136	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	442,584	equal to	442,584	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,349,681	equal to	1,349,681	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,878,381	equal to	2,878,381	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,333,718	equal to	1,333,718	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	236,234	equal to	236,234	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	445,449	equal to	445,449	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	79,935	equal to	79,935	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,438,286	equal to	1,525,662	-87,376	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	44,369	equal to	47,134	-2,765	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	78,231	equal to	78,231	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	79,885	equal to	154,701	-74,816	FAILED	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	271,624	equal to	271,624	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	303,018	equal to	303,018	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	34,740	equal to	34,740	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	38,625	equal to	38,625	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	63,269	equal to	63,269	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	146,148	equal to	146,148	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,663,152	equal to	2,663,152	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	6,475	< or = to	45,227	-38,752	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	15,500	< or = to	15,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	849,003	< or = to	849,003	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	800	< or = to	2,524	-1,724	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	63,269	equal to	63,269	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	428,048	equal to	428,048	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,601	equal to	8,601	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	607,651	equal to	607,651	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,644	equal to	2,644	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav		equal to	0	#VALUE!	#VALUE!	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	79,935	equal to	79,935	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,310	equal to	3,310	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	79,152	equal to	79,152	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	221,420	equal to	221,420	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,777,046	equal to	3,777,046	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,354,247	equal to	1,354,247	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,266,190	equal to	4,266,190	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,145,060	equal to	2,145,060	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-33,362	equal to	-33,362	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	2,785	equal to	2,785	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,303,365	equal to	5,303,365	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1